SOUTH TEXAS EYE CENTER

Date _____

Who referred you _____

Which Dr. are you seeing? McMahon or McCollough

Name _____ DOB _____

Sex _____ Address _____

City _____ State, Zip _____

Email _____ Race _____

Home _____ Cell _____

Work _____SS# _____-_____-_____

(Please Circle) Single Married Divorced Widowed

Emergency Contact _____

Phone _____

Spouse/Guardian _____

Phone_____

Medical Insurance _____

Vision Insurance _____

SOUTH TEXAS EYE CENTER

ROBERT T. MCMAHON, M.D.
JOHN MCCOLLOUGH, O.D.

4406 N. LAURENT
VICTORIA, TEXAS 77901
www.southtexaseyecenter.com

(361)578-0107
(800)352-5928
FAX (361)578-1320

ACKNOWLEDGEMENT OF PRIVACY PRACTICE

I have been offered or given a copy of South Texas Eye Center notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPPA).

_____ _____ _____

(PATIENT NAME – PRINT) (SIGNATURE) (DATE)

HOW MAY WE CONTACT YOU? PLEASE CHECK ALL PERMISSIBLE:

I hereby give permission to leave message:

__ with the person who answers the phone at the residence.

__ on my phone answering machine, or cell phone voicemail.

__ on my work phone answering machine, or voicemail.

__ on any number I have listed.

__ by post card via mail.

_____ (SIGNATURE) _____ (DATE)

I _____ herby authorize South Texas Eye Center to release any medical information to the following: _____

_____

_____ (SIGNATURE) _____ (DATE)

MORE ON THE BACK PLEASE TURN OVER.

4406 N. LAURENT
VICTORIA TX,77901
OFFICE (361)578-0107
FAX (361)578-1320

ROBERT T. MCMAHON, M.D.
JOHN S. MCCOLLOUGH, O.D.

SOUTH TEXAS EYE CENTER

PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT

Your signature below forms a binding agreement between South Texas Eye Center (STEC-the provider of vision services) and the Patient who is receiving vision services or the Responsible Party for minor patients (those patients under 18 years old) Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

MEDICAL INSURANCE: We have contracts with many Insurance companies, and we will bill your primary as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Pay refraction fee of $40.00 Refraction are how the doctor determines your prescription for glasses and/or contacts. It is the patient's responsibility.
- Inform STEC of the current address and phone number for the patient and the responsible party.
- Present all current Insurance cards prior to each office visit.
- Verify at each visit that the information is current by filling out our data sheet.
- Pay any required copay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. (When STEC receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).
- Obtain a referral prior to your visit, if your insurance requires one.

Return Check Policy

If a payment is made on account by check, and the check is returned as Non-Sufficient Funds (NSF). Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $30.00 service charge. Once notice is received of the returned check, STEC will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account will be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $30.00 check service charge.

Medicare Patient

Medicare has a deductible at the beginning of every year that the patient will be responsible for paying unless your secondary insurance is covering your deductible.

Medicaid Patient

Medicaid patients be aware that Medicaid only covers a medical diagnosis, if you are only coming in for a Routine Eye Exam then it will be patient's responsibility.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement. Understand your responsibilities and agree to these terms.

Patient Name (Print) _____

Patient Signature _____ Date_____

Responsible Party Name (Print)_____

Responsible Party Signature_____ Date_____